

HOSPICE CARE SERVICES



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INTRODUCTION

Hospice provides health care and support services to a terminally ill Medicaid or dually eligible recipient and to the recipient's family. Recognizing the impending death, hospice care is an approach to treatment focusing on palliative rather than curative care. Hospice care includes attending to the emotional, spiritual, social and medical needs of the terminally ill recipient and the family. The hospice provider seeks to help the recipient and the family to come to terms with the terminal condition and help the recipient live the remaining days of life as comfortably, functionally and normally as possible.

DEFINITIONS

1. "Employee means a person employed by a hospice, or if the hospice is a subdivision of an agency or organization, a person employed by an agency or organization who is assigned to the hospice unit, or a volunteer under the supervision of the hospice.
2. "Hospice care" means the multidisciplinary services provided by a hospice to a terminally ill recipient who resides at home or in a long-term care facility, including a nursing facility, a swing bed, or an intermediate care facility for the mentally retarded.
3. "Inpatient care" means hospice services provided by an inpatient facility to a recipient who has been admitted to an inpatient facility that provides 24 hour a day care.
4. "Inpatient facility" means a hospital or nursing facility that provides care 24 hours a day and the facility is not considered to be the recipient's residence.
5. "Inpatient respite care" means short-term inpatient care provided to a hospice recipient to relieve family members or caregivers.
6. "Palliative care" means care directed at managing the symptoms experienced by the hospice recipient and intended to enhance the quality of life for the hospice recipient and the recipient's family. Palliative care does not include care directed at curing a disease.
7. "Terminally ill" means a recipient has a medical prognosis of a life expectancy of six months or less as determined by a physician.

PROVIDERS

A hospice provider may enroll as a Medicaid provider if it is licensed as a hospice provider by the Department of Health and certified by Medicare as a provider of hospice services. Hospice care services provided to dually eligible recipients must be provided first in

accordance with Medicare policies, rules, regulations, and guidelines, and second by the Medicaid policies set forth in this manual.

HOSPICE CARE ELIGIBILITY REQUIREMENTS

1. A recipient must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a recipient is no longer certified as terminally ill or until the recipient or representative revokes the election of hospice.
2. A recipient may live in a home in the community or in a long-term care facility while receiving hospice services.
3. A dually eligible recipient must elect or revoke hospice care simultaneously under both the Medicare and the Medicaid programs.

PHYSICIAN CERTIFICATIONS

A written certification statement signed by the medical director of the hospice or a physician member of the hospice interdisciplinary group and the recipient's attending physician, if the recipient has one, should be obtained within two calendar days after hospice care is initiated. If the hospice does not obtain a written certification within two calendar days after hospice care is initiated, a verbal certification must be obtained within the two calendar days and a written certification must then be obtained no later than eight days after care is initiated if a verbal certification was provided.

If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification. The certification statement must include a statement indicating the recipient's medical prognosis is a life expectancy of six months or less.

ELECTION OF HOSPICE CARE

1. A recipient who is eligible for hospice care and who wishes to elect hospice care, must sign an election statement. The election statement must include:
 - a. The name of the hospice providing care.
 - b. An acknowledgment of the recipient's understanding that hospice provides palliative, not curative care for the terminal illness.
 - c. An acknowledgment that the recipient waives all rights to Medicaid payments for the duration of the election of hospice care for the following services:

- 1) Hospice care provided by a hospice other than the hospice designated in the election statement unless the care is provided under arrangements made by the designated hospice.
- 2) Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected; a related condition; or equivalent to hospice care except for:
 - a) Services provided directly or under arrangement by the designated hospice.
 - b) Services provided by the recipient's attending physician if the physician is not an employee of or receiving compensation from the designated hospice.
 - c) Room and board provided by a nursing facility or ICF/MR if the recipient is a resident of the facility.
 - d) Medically necessary transportation.
- d. The effective date of the election.
- e. The signature of the recipient.
2. A legal representative of the recipient may act on behalf of the recipient in all matters pertaining to hospice care.

REVOCATION OF ELECTION OF HOSPICE CARE

1. A recipient may revoke the election of hospice care at any time by signing and dating a revocation statement, which indicates the effective date of the revocation of hospice care. The effective date of the revocation must be on or after the date the form is signed.
2. After revoking the election, a recipient may receive any of the Medicaid benefits that were waived when the individual elected hospice care.
3. A recipient may elect hospice again at any time if they are eligible for hospice care benefits.

CHANGE OF DESIGNATED HOSPICE PROVIDER

1. A recipient may change the designation of the hospice provider from which the recipient chooses to receive care. A change of the designated hospice provider is

not a revocation of the election. The recipient must sign a statement indicating the name of the hospice provider from which the recipient was receiving care, the name of the newly designated hospice provider and the effective date of the change. Both hospice providers must maintain a copy of the statement.

2. A change of ownership of a hospice requires no action by the recipient.

NOTIFICATION TO THE DEPARTMENT

1. A statement of certification, election, or revocation of election must be sent to the Department within two working days after the hospice provider obtains the signed statement from the recipient. Payment for hospice services will not be made until the Department has received the appropriate documents.
2. Each hospice provider is to design and print its own statements of certification, election, or revocation of election. For recipients dually eligible for Medicare and Medicaid, the statements used for Medicare may be used if appropriate references to Medicaid are included, for example, an election form could include a statement acknowledging the recipient waives Medicaid as well as Medicare benefits.

DEVELOPING A PLAN OF CARE

1. An interdisciplinary team must assess a recipient's needs and develop a written plan of care before services can be provided. Services provided by the hospice must be consistent with the plan of care and must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.
2. At least two members of the interdisciplinary team must be involved in development of the initial plan of care and one of these individuals must be a nurse or physician. The other members of the interdisciplinary team must review and provide input to the plan of care within two working days following the day of assessment.

COVERED SERVICES

The hospice must provide the services listed below. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personnel.

1. Core Services
 - a. Nursing services provided by or under the supervision of a registered nurse.

- b. Social services provided by a social worker under the direction of a physician.
- c. Services performed by a physician, dentist, optometrist, or chiropractor.
- d. Counseling services provided to the recipient and family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or caregiver to provide care and help the recipient, family members, and caregivers adjust to the recipient's approaching death.

2. Supplemental Services

- a. Inpatient hospice care including procedures necessary for pain control and acute or chronic symptom management.
- b. Inpatient respite care.
- c. Medical equipment supplies and drugs. Medical equipment including self-help and personal comfort items related to the palliation or management of the recipient's terminal illness must be provided by the hospice for use in the recipient's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the recipient's terminal illness.
- d. Home health aid services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the recipient. Aide services must be provided under the supervision of a registered nurse.
- e. Physical therapy, occupational therapy, and speech and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

INPATIENT HOSPICE CARE

A recipient may need care as an inpatient on a short-term basis during a period of crisis. To meet this need, the hospice or facility under contract to provide inpatient hospice care must provide 24-hour nursing services. Nursing services must be sufficient to meet the total nursing needs and be consistent with the recipient's plan of care. The inpatient facility must provide treatments, medications, and diet as prescribed, and keep the recipient comfortable, clean, well groomed, and protected from accident, injury, and infection. The inpatient facility must employ a registered nurse on each shift to provide nursing care.

INPATIENT RESPITE CARE

Inpatient respite care may be provided on an occasional basis to give the recipient's family or caregiver a break from the full-time responsibility of providing care. Payment for inpatient respite care may not exceed five consecutive days of inpatient respite care at a time.

BEREAVEMENT COUNSELING

The hospice must make bereavement services available to the recipient's family for at least one year after the recipient's death. Family includes persons related to the recipient or those considered by the recipient to be family because of close association. No payment is made for bereavement counseling.

PAYMENT FOR HOSPICE SERVICES

1. The hospice provider is paid at one of four predetermined rates for each day a recipient is under the care of the hospice. The four rates exclude payment for physician services that are separately paid. The Medicaid program uses the rates established by The Centers for Medicare and Medicaid Services (CMS), to pay Medicaid hospice services on a prospective basis. Retroactive adjustments may be made to payments when a limitation on payments for inpatient care is applicable.
2. The hospice provider is paid an amount applicable to the type and intensity of services provided each day to the recipient. The four levels of care into which each day of care is classified are:
 - a. Routine Home Care – This level of care is used for each day the recipient is under the care of the hospice and the recipient is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided.
 - b. Continuous Home Care – This level of care is used for each day the recipient receives nursing services on a continuous basis during a period of crisis in the recipient's home. The hospice is paid an hourly rate for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.
 - c. Inpatient Respite Care – This level of care is for each day a recipient is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to 5 consecutive days beginning with the day of admission, but excluding the day of discharge. Any inpatient respite care days in excess of 5 consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a recipient resides in a long-term care facility.

- d. General Inpatient Care – This level of care is for each day the recipient receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that can't be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the recipient is discharged deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the resident's home; however, payment for general inpatient care can be made to another long-term care facility.
3. Payment for inpatient care days will be limited according to the number of days of inpatient care furnished to Medicaid recipients by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed twenty percent of the total number of days of hospice care provided to all Medicaid recipients by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate, and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to recipients diagnosed with acquired immunodeficiency syndrome (AIDS).

PAYMENT FOR PHYSICIAN SERVICES

1. The daily rates paid for hospice care include payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of care plans, supervision of care and service, periodic review and updating of care plans, and establishment of governing policies. The cost of these activities may not be billed separately.
2. The hospice may be paid at the current Medicaid rate for physician services provided for purposes other than those listed above if the physician is an employee of the hospice or provides services under arrangement with the hospice. Payment is not available for donated physician services.
3. Payment may be made for personal professional services provided by a recipient's attending physician, if the physician is not an employee of the hospice, not providing services under arrangement with the hospice, or does not volunteer services to the hospice. Costs for services other than personal professional services, such as lab or x-ray, may not be included on the attending physician's bill and may not be billed separately.

ROOM AND BOARD PAYMENT FOR RECIPIENT IN LONG-TERM CARE FACILITY

1. When hospice care is furnished to a recipient residing in a long-term care facility, payment to the long-term care facility by the Medicaid program is no longer

available, and the hospice is responsible for paying for room and board furnished by the long-term care facility. A room and board payment equal to the Medicaid rate payable to the long-term care facility at the time the services are provided will be made to the hospice. The hospice may not negotiate a room and board rate with the long-term care facility with the exception of payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates. No retroactive adjustments are available for changes in the Medicaid rate made subsequent to the payment of room and board. Adjustments may be made to correct errors in billing.

2. If a recipient has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the recipient. The hospice may make arrangements with the long-term care facility to collect the recipient liability. The Department will not reimburse the hospice for any uncollected recipient liability.

BILLING PROCEDURES

1. A hospice claim must be submitted for all individuals electing hospice who are Medicaid eligible even if no payment is due from Medicaid and payment is made entirely by Medicare, insurance, or any other payment source.
2. Hospice services, and room and board charges must be billed on a UB-92. If billing more than one level of care, a separate bill must be prepared each time the level of care changes during the hospice's billing period. A billing period is defined as a calendar month or a portion of a calendar month.
3. The following information must be completed to bill for hospice services. For additional instructions on completion of the UB-92, refer to the UB-92 procedure manual.

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| Box 1 | Enter the name of the hospice provider as identified by the Department. |
| Box 4 | Enter the bill type. Only bill types 811 through 814 may be used. |
| Box 6 | Enter the period covered by the claim. Period can be for any or all of a month but cannot be for more than one month. |
| Box 7 | Enter the number of covered days. Days must agree with the dates entered in box 6. |
| Box 12 | Enter recipient's full name as identified by the Department. |

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| Box 13 | Enter recipient's address. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Box 17, 19, 20 | Enter admission data. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Box 22 | Enter discharge information. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Box 42 | <p>Enter revenue Code 659 for Room and Board charges</p> <p>Enter only one of the following procedure codes for hospice services:</p> <p>651 Routine Home Care 652 Continuous Home Care 655 Inpatient Respite Care 656 General Inpatient Care</p> <p>Revenue Code 659 may not be billed with 655 or 656.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Box 43 | <p>Enter the description of the procedure. If billing for room and board, enter the resident's nursing facility classification or identify the type of long-term care services. The descriptions to be used for room and board are:</p> <table> <tr><td>RAD</td><td>Rehabilitation</td></tr> <tr><td>RAC</td><td>Rehabilitation</td></tr> <tr><td>RAB</td><td>Rehabilitation</td></tr> <tr><td>RAA</td><td>Rehabilitation</td></tr> <tr><td>SE3</td><td>Extensive Services</td></tr> <tr><td>SE2</td><td>Extensive Services</td></tr> <tr><td>SE1</td><td>Extensive Services</td></tr> <tr><td>SSA</td><td>Extensive Services</td></tr> <tr><td>SSC</td><td>Special Care</td></tr> <tr><td>SSB</td><td>Special Care</td></tr> <tr><td>SSA</td><td>Special Care</td></tr> <tr><td>CA1</td><td>Special Care</td></tr> <tr><td>CC2</td><td>Clinically Complex</td></tr> <tr><td>CC1</td><td>Clinically Complex</td></tr> <tr><td>CB2</td><td>Clinically Complex</td></tr> <tr><td>CB1</td><td>Clinically Complex</td></tr> <tr><td>CA2</td><td>Clinically Complex</td></tr> <tr><td>CA1</td><td>Clinically Complex</td></tr> <tr><td>IB2</td><td>Impaired Cognition</td></tr> <tr><td>IB1</td><td>Impaired Cognition</td></tr> <tr><td>IA2</td><td>Impaired Cognition</td></tr> <tr><td>IA1</td><td>Impaired Cognition</td></tr> <tr><td>BB2</td><td>Behavior Only</td></tr> </table> | RAD | Rehabilitation | RAC | Rehabilitation | RAB | Rehabilitation | RAA | Rehabilitation | SE3 | Extensive Services | SE2 | Extensive Services | SE1 | Extensive Services | SSA | Extensive Services | SSC | Special Care | SSB | Special Care | SSA | Special Care | CA1 | Special Care | CC2 | Clinically Complex | CC1 | Clinically Complex | CB2 | Clinically Complex | CB1 | Clinically Complex | CA2 | Clinically Complex | CA1 | Clinically Complex | IB2 | Impaired Cognition | IB1 | Impaired Cognition | IA2 | Impaired Cognition | IA1 | Impaired Cognition | BB2 | Behavior Only |
| RAD | Rehabilitation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RAC | Rehabilitation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RAB | Rehabilitation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RAA | Rehabilitation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SE3 | Extensive Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SE2 | Extensive Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SE1 | Extensive Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SSA | Extensive Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SSC | Special Care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SSB | Special Care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SSA | Special Care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CA1 | Special Care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CC2 | Clinically Complex | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CC1 | Clinically Complex | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CB2 | Clinically Complex | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CB1 | Clinically Complex | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CA2 | Clinically Complex | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CA1 | Clinically Complex | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IB2 | Impaired Cognition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IB1 | Impaired Cognition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IA2 | Impaired Cognition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IA1 | Impaired Cognition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BB2 | Behavior Only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

BB1 Behavior Only
 BA2 Behavior Only
 BA1 Behavior Only
 PE2 Reduced Physical Functioning
 PE1 Reduced Physical Functioning
 PD2 Reduced Physical Functioning
 PD1 Reduced Physical Functioning
 PC2 Reduced Physical Functioning
 PC1 Reduced Physical Functioning
 PB2 Reduced Physical Functioning
 PB1 Reduced Physical Functioning
 PA2 Reduced Physical Functioning
 PA1 Reduced Physical Functioning
 Swing Bed
 ICF/MR

- Box 46 Enter the number of units that correspond to the date span in box 6. For procedure codes 659, 651, 655 and 656 each unit equals one day. For procedures code 652, each unit equals one hour. For procedure code 652, a minimum of 8 units and a maximum of 24 units must be billed on a day of service.
- Box 47 Enter the total charges. This must equal the Medicaid rate payable, times the number of units. The rates for nursing facilities, swing beds and ICF/MR's change annually. The current rates should be obtained from the long-term care facility.
- Box 51 Enter the hospice's Medicaid provider number.
- Box 54 Enter any insurance payments. Do not include recipient liability.
- Box 55 Enter the total amount due from Box 47.
- Box 60 Enter the recipient's Medicaid identification number.
- Box 67-75 Enter the principal and secondary diagnosis codes.
- Box 82 Enter the attending physician's UPIN.
- Box 85, 86 Sign and date the claim form.